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ORIGINAL ARTICLE

From Madness to International Mad Activism

My Madness is a politically responsive coping mechanism to an unjust world, and at times a superpower

Matthew Jackman

Faculty of Medicine and Health, University of Sydney

Abstract
In this paper, I delve into the intricacies of Madness, exploring its origins, manifestations, and its role in shaping my international activism, academic pursuits, and worldview. Through personal narrative interwoven with theoretical insights and lived experiences, I navigate the complexities of identifying as Mad in a world marked by divergent truths and multiverses. From grappling with grief, trauma, and oppression to embracing post-traumatic growth, I reframe Madness as not merely a burden but a profound gift, a superpower, and a source of strength. I challenge prevailing notions of mental illness, advocating for a paradigm shift towards understanding Madness as a valid coping mechanism and a response to systemic injustice. My journey unfolds from childhood to active engagement in international activism, underscoring the political nature of Madness and its transformative potential.

Keywords
Madness, lived experience, activism, trauma, transformation

History
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Introduction

Join me as I share my journey from survival to empowerment, weaving together personal anecdotes, theoretical frameworks, and activism to illuminate the intersection of Madness and advocacy. Through narrative storytelling, I invite readers to journey alongside me, fostering dialogue, reflection, and collective growth. I will cover the following topics:

- Exploring Madness, drawing on La Murr Jurelle Bruce’s conceptualizations. I offer insight into the multifaceted nature of Madness, shaped by trauma, grief and societal oppression.

CORRESPONDENCE: Matthew Jackman, matthewrjackman@outlook.com

- Personal reflections, where I delve into my family background and the legacy of intergenerational trauma. I shed light on how Madness has served as a coping mechanism amidst adversity.
- Finally, advocacy through Madness. Through firsthand experiences, including a transformative stint in a psychiatric hospital, I demonstrate how Madness can be harnessed as a catalyst for advocacy and social change.

Image description: A portrait drawn by the author showing a child sitting on the floor, with his arms wrapped around his bent legs. The child is positioned in the bottom right corner of the tall, rectangular portrait on a textured, but abstract background. The child is drawn in peach, rust, copper, bronze shades, and the background is a warm, charcoal grey colour. Upon admission to a public psychiatric hospital for the first time, I spent 7 weeks inside an art room. I drew a portrait of myself aged approximately five years of age depicting the loneliness I felt having been removed from my parents due to my mother’s mental health, domestic and family violence, and lack of resources leading to a childhood living in severe material poverty.

1. Who am I? Situating myself.

Who Am I? The person

It is paramount to understand and contextualize our identities within the framework of social structures and relations, as they shape our experiences, opportunities, and perceptions of the world. My identity encompasses various facets that influence how I navigate life and advocate for change.

I am a white individual of Anglo-Saxon and Celtic Irish descent, designated male at birth but identifying as non-binary, embracing the pronouns they/them. As a queer person from a fluctuating middle-class background, I hold citizenship and actively participate in the disability and psychiatric survivor community. My identity is intertwined with a psychosocial disability, specifically shaped by my responses to trauma.

My upbringing was marked by involvement with social systems, including cycles of home care, foster care, and psychiatric interventions. I endured experiences of abuse, neglect, grief, and trauma within my familial, intergenerational, and broader community contexts.

In resistance to medicalization and pathologization of my experiences, I align with the Mad Pride identity. I am part of movements advocating for the rights of consumers, psychiatric survivors, former patients, and neurodiverse individuals. My identity as Mad reflects a rejection of societal norms and a reclaiming of agency in shaping narratives around mental health and well-being.

Who am I? The Professional

As a trained social worker and peer worker, my professional journey has been shaped by a commitment to advocacy, empowerment, and transformative change within the mental health landscape. My academic background spans Mad Studies and Public Health, with a current focus on pursuing a PhD at the University of Sydney, exploring how Madness and the Mad Movement can catalyze transformative shifts in mental health paradigms.

My professional experience includes roles in forensic mental health settings, notably at Thomas Embling Hospital, akin to the Broadmoor Hospital, where I worked closely with individuals navigating complex intersections of mental health and the legal system. Additionally, I served as a counselor and group therapist at the Melbourne Assessment Prison and Metropolitan Remand Centre, providing support within correctional settings.

Within the realm of systemic advocacy, peer support, and service evaluation, I contributed as part of the Lived Experience team, fostering dialogue and driving change from within mental health systems. Building upon this foundation, I established my own mental health startup, 'The Australian Centre for Lived Experience (TACFLE)', aimed at amplifying the voices of individuals with lived experience and advocating for inclusive, person-centered approaches to mental health care.

Furthermore, my commitment to international advocacy is reflected in my collaborations with organizations such as the Global Mental Health Peer Network, CMB International, World Health Organization, Lancet, and Harvard Global Mental Health, where I contribute to global conversations surrounding mental health policy, practice, and advocacy.

2. What is madness?

Madness, a concept fraught with complexity and nuance, eludes fixed definition as it navigates the intricate terrain of social construction and lived experience. On one hand, Madness emerges as a floating signifier, a dynamic construct shaped by cultural, historical, and societal forces. Its elusive nature defies rigid categorization, continuously evolving in response to shifting social norms and contexts. Yet, on the other hand, Madness is undeniably a lived reality, demanding attention and recognition of its profound impact on individuals' lives.

In exploring the multifaceted nature of Madness, La Marr Jurelle Bruce's (2021) theory offers valuable insights into its diverse manifestations within the modern Western context. Bruce contends that Madness encompasses at least four overlapping entities, each contributing to the complex tapestry of human experience and perception:

First: Phenomenal madness

At the core of Bruce's theory lies the concept of phenomenal Madness, which encompasses an intense unruliness of the mind. This unruliness extends beyond conventional notions of mental health and disrupts fundamental aspects of perception, emotion, meaning, and selfhood within the consciousness of the individual. Phenomenal Madness is characterized by a profound sense of disorientation and dissonance, evoking a spectrum of sensations ranging from distress and despair to exhilaration and euphoria. Rooted in spirituality, existentialism, grief, trauma, and emotional overwhelm, phenomenal Madness challenges normative understandings of reality and invites individuals to confront the complexities of human experience in all its richness and diversity.

Second: Medicalized madness

Within the realm of medicalized Madness, individuals often find themselves ensnared within a web of diagnostic labels and clinical categories, stripping away their complexity and humanity. These labels, ranging from schizophrenia and bipolar disorder to borderline personality disorder and beyond, are codified by the disciplines of psychiatry, psychology, and psychoanalysis, shaping one's identity within the confines of the psychiatric gaze.

The process of medicalization extends beyond mere diagnosis, permeating into every aspect of an individual's lived experience. Acronyms such as BD/BPAD (bipolar disorder), cPTSD (complex post-traumatic stress disorder), GAD (generalized anxiety disorder), MDD (major depressive disorder), ADHD (attention-deficit/hyperactivity disorder), and ASD (autism spectrum disorder) become markers that define one's existence, reducing complex human experiences to a collection of letters and symbols.

The dehumanizing effects of medicalized Madness are profound and far-reaching. Individuals are often reduced to their diagnoses, overshadowing their unique identities, strengths, and aspirations. The psychiatric gaze, characterized by its reductionist approach to mental health, fails to capture the richness and diversity of human experience, perpetuating stigma and marginalization.

Having a myriad of diagnostic acronyms slapped onto one's identity can be a deeply dehumanizing and disempowering experience. It's like being reduced to a list of symptoms and conditions, stripped of the complexities, nuances, and richness that make up a person's identity. Each acronym becomes a label, a shorthand way for others to categorize and define you, often overlooking the individual behind the diagnosis.

Living with these labels can feel like carrying a heavy burden, as they come with societal expectations, stereotypes, and stigma. Others may perceive you through the lens of your diagnoses, leading to assumptions, prejudices, and misconceptions about your capabilities, character, and worth. It can be frustrating and isolating to constantly navigate these misconceptions, feeling misunderstood, judged, or dismissed by those around you.

Moreover, having multiple acronyms associated with your identity can further compound these challenges, as each diagnosis brings its own set of challenges, treatments, and implications. It can feel overwhelming to juggle the demands of managing multiple conditions while also striving to live a fulfilling and meaningful life.

Furthermore, the medicalization of one's identity can erode a sense of agency and autonomy, as individuals may feel like passive recipients of treatment rather than active participants in their own care. The emphasis on pathology and deficits can overshadow one's strengths, resilience, and potential for growth, perpetuating feelings of hopelessness and helplessness.

Despite these challenges, many individuals find resilience and strength in their experiences, forging connections, advocating for change, and reclaiming their narratives from the confines of medicalized discourse. By fostering understanding, empathy, and solidarity, we can work towards creating communities that honor the complexity and humanity of each individual, regardless of their diagnostic labels.

Third: Rage

Rage, as defined by Bruce, encompasses an affective state of intense and aggressive displeasure, often stemming from experiences of systemic oppression, injustice, and marginalization. Particularly within the context of Black communities in the United States and elsewhere, rage emerges as a response to heinous violence and degradation, with individuals rarely granted recourse or redress. However, when Black individuals articulate their rage in public spheres, they are often met with harsh consequences: criminalization as threats to public safety, caricatured as angry black stereotypes, and pathologized as "insane." This phenomenon illustrates how antiblack logics tend to conflate justified anger with madness, perpetuating harmful stereotypes and further marginalizing oppressed communities.

While rage manifests uniquely within Black communities, there are parallels and differences with other intersecting social identities and locations, such as gender, sexuality, class, and material deprivation. Individuals, groups, and communities experiencing disempowerment due to systems of privilege often have legitimate reasons to feel rageful, yet their expressions of anger are frequently portrayed as mad to demonize human responses to injustice. This dynamic underscores the ways in which marginalized voices are silenced, pathologized, and delegitimized within dominant narratives.

From lived and living experiences, there is a tendency for anger and emotional overwhelm to exceed conventional coping mechanisms, resulting in forms of Madness that challenge societal norms of emotional expression and resilience. This divergence from normative coping responses is particularly pronounced in societies where emotions, especially uncomfortable ones like rage, tend to be suppressed or invalidated. However, it's important to note the nuanced relationship between justified rage and pathological medicalization. While rage may be a legitimate response to oppression, there exists a risk of medicalization wherein individuals' expressions of anger are pathologized and classified as pathological, failing to acknowledge the societal structures and experiences that drive such emotional responses.

In essence, Bruce's exploration of rage highlights the intersectionality of anger, oppression, and Madness, shedding light on the complex interplay of social, cultural, and psychological factors that shape individuals' experiences and perceptions of reality. This nuanced understanding invites us to challenge dominant narratives, dismantle oppressive systems, and advocate for genuine recognition and validation of marginalized voices and emotions.

Fourth: Psychosocial Madness

Psychosocial madness represents a profound departure from societal norms within a given psychosocial context. It encompasses a wide range of behaviors, practices, and identities that defy conventional expectations and challenge the prevailing notions of normalcy.

Unlike medicalized madness, which is often defined and enforced by psychiatric experts, psychosocial madness is determined by the collective judgments of individuals and communities who adhere to psychonormative common sense.

Throughout history, acts and attributes associated with psychosocial madness have been met with skepticism, condemnation, and ostracization by mainstream society. For example, expressions of insurgent blackness, slave rebellion, willful womanhood, anticolonial resistance, same-sex desire, and gender subversion have all been marginalized and pathologized as "crazy" by dominant cultural narratives. These acts of defiance and resistance challenge the status quo, unsettling established power structures and social hierarchies in the process.

What distinguishes psychosocial madness from other forms of madness, such as phenomenal madness, is its emphasis on the willful disruption of societal norms and expectations. While phenomenal madness often manifests as an unruliness of the mind, psychosocial madness reflects an unruliness of will—a conscious decision to resist and subvert the prevailing regimes of normalcy. This may involve engaging in behaviors that push the boundaries of gender, fashion, appearance, or social conduct, such as playing with gender norms, experimenting with unconventional hairstyles or fashion choices, engaging in public displays of singing or dancing, or even engaging in self-expression through public conversations with oneself.

The intersectionality of psychosocial madness is a critical aspect to consider, as it highlights the disparities in how deviant behavior is perceived and treated based on intersecting social identities. For example, an upper-class white individual's eccentricities may be perceived as charming or endearing, whereas similar behaviors exhibited by a marginalized individual, such as a poor Black person, may be pathologized and deemed as madness. This underscores the influence of privilege, power dynamics, and societal expectations in shaping perceptions of madness and deviance.

Ultimately, exploring psychosocial madness prompts us to question and challenge the norms and conventions that govern social behavior. By recognizing and validating the diversity of human experiences and expressions, we can work towards creating more inclusive and equitable societies that embrace individual autonomy, agency, and self-expression.

3. Madness as a response to social, cultural, spiritual and structural/ political determinants.

Madness often emerges as a response to a complex interplay of social, cultural, spiritual, and structural/political determinants. Causative factors include trauma, grief, loss, disconnection-isolation, neglect-deprivation, and injustice-oppression. These elements intersect and compound, shaping individuals' experiences and expressions of madness within society.

The predominant approach within the mental health system is rooted in a medical model, which often focuses on diagnosing and treating individuals based solely on their symptoms. This approach tends to pathologize mental health conditions, viewing them primarily as individual disorders or dysfunctions to be addressed through medical interventions. However, if we truly aspire to address mental health in its entirety, we must move beyond this narrow framework and confront the underlying social determinants that contribute to mental distress.

A comprehensive understanding of mental health requires us to delve deeper into the societal structures and systemic inequalities that shape individuals' experiences. Factors such as violence, discrimination, inequality, poverty, and various forms of oppression play significant roles in exacerbating mental health challenges, particularly among marginalized groups. For example, individuals who face discrimination based on their race, ethnicity, gender identity, sexual orientation, socioeconomic status, or disability status are more likely to experience heightened levels of stress, trauma, and social exclusion, all of which can contribute to mental health issues.

Addressing mental health effectively requires a multifaceted approach that encompasses not only individual-level interventions but also broader social and structural changes. This includes challenging discriminatory policies and practices, advocating for equitable access to resources and opportunities, and creating supportive environments that foster resilience and well-being. By addressing the root causes of mental distress, such as systemic inequality and social injustice, we can work towards creating healthier and more inclusive communities where all individuals have the opportunity to thrive.

My childhood: intergenerational historical context

The intergenerational historical context deeply influences our vulnerabilities, shaping the experiences and trajectories of individuals within families. In my own family history, the story of my maternal grandmother, Nan, and my paternal grandfather, Pa, illustrates the complexities of intergenerational dynamics and the transmission of vulnerabilities across generations.

Nan hailed from a large family in Daylesford, where she assumed the role of caretaker for some of her siblings with disabilities. Despite her aspirations for a career beyond motherhood, she pursued a teaching profession after attending teachers' college. This vocational identity remained significant to her, reflecting her desire for fulfillment beyond traditional gender roles.

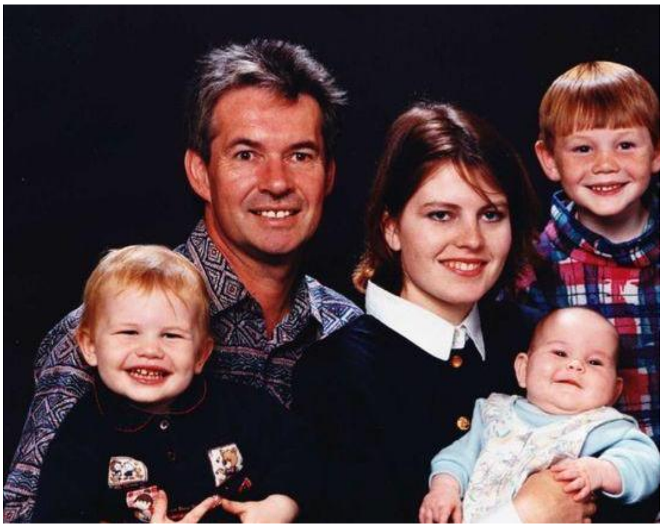


Image description: A family portrait showing a white man and woman sitting down each holding a young child, and an older child standing in the background beside the woman. Everyone is facing forward and smiling. The older child has light reddish brown hair. He is wearing a red, white, and blue plaid sweater. The man has a full head of dark, greying hair, and is wearing a long-sleeved shirt with a blue and grey diamond pattern. He is holding a blond, toddler-aged child wearing a black sweater with small square images placed across the front. The woman has auburn hair, wearing a black sweater with shiny copper colored buttons, and a crisp white collar. She is holding an infant-aged child wearing a light blue long-sleeved shirt, and a patterned white and light grey sweater vest.

Pa, on the other hand, experienced early loss and inherited familial responsibilities, inheriting the family home in Hawthorn after the premature deaths of both his Irish parents. His aspiration for a large family intersected with Nan's desire for security, leading to their marriage and the exchange of goals and resources that would reverberate through subsequent generations.

Despite Nan's professional aspirations, she grappled with the demands of motherhood, expressing to my mother her reluctance to have children and seeking respite by sending her own children – my mother and her brother – away to Daylesford at times. I endeavor to view Nan's struggles through a feminist lens, acknowledging the suffocating constraints of traditional gender roles and the toll they took on her mental health.

However, the impact of Nan's choices on subsequent generations cannot be overlooked. The sense of abandonment experienced by my mother, Samantha, and the replication of this pattern with their grandchildren, including myself, echoes through familial relationships to this day. While I strive to understand the complexities of Nan's circumstances, the wounds of abandonment persist, underscoring the intergenerational transmission of vulnerabilities within our family narrative.

Image description: A school picture of the author's 15 year old mother. She has brown eyes and is smiling into the camera. She has shiny, straight shoulder-length auburn hair with bangs. She is wearing a grey school uniform jacket with white pinstripes, and a red and white embroidered school badge on the chest, and a white and blue striped polo shirt with a large white collar.

Samantha was a bright, humorous, deeply sarcastic, academic and personable soul known for her kindness and cackle. She meticulously documented life, through photographs, letters and cards that were dated and located. The ultimate historian.

My Pa had told me she was bullied for being a poorer student at school, and heading to her extended family farm for summer, whilst her peers went abroad. He had informed me one of the girls spat on her in Year 9. This broke my heart.

My mother struggled in a household that kept her isolated. She stayed up late to study and was rarely allowed friends over. My grandparents had high hopes for her, my Pa, a Medical Scientist at RMIT University and Melbourne Pathology had missed out on medical school and pressured my mother to head down that path.

I think the pressure of parental expectation, disruption in her attachment with Nan, social isolation and bullying shaped an identity of being a misfit: someone who never really found their tribe, their community and their sense of belonging.

Consequently, she left school and her family home around the age of 16/17 years old, and found my father, who was some seventeen years older than her and had five children from a previous marriage which had not been revealed until months into their relationship.

Nevertheless, from that intergenerational shitshow and burgeoning relationship, I was born!

What more could go wrong?!

Image description: A white man and woman holding the author as a one week old infant. The man is wearing a dark grey suit, white dress shirt, and dark blue tie. The woman is wearing red earrings and a red dress with a white pattern. The woman is breastfeeding while both smile at the camera.

The social and structural conditions surrounding our family were fraught with tension and adversity, precipitating a cascade of distressing events that profoundly impacted our collective well-being.

The relationship between my parents was met with staunch disapproval from my maternal grandparents, who gradually withdrew their support for Samantha as their relationship progressed. Despite my Pa's clandestine efforts to offer assistance, covertly circumventing the watchful gaze of my resentful Nan, the strain of familial discord took its toll on my parents' relationship. With the loss of my father's parents, our familial network became increasingly fractured, leaving us isolated and bereft of crucial social supports.

The absence of familial and social networks compounded the challenges my parents faced, shifting their focus towards self-preservation amid the tumultuous circumstances. My brother's arrival three years later, coupled with Samantha's postnatal depression, further strained our family dynamics. My father assumed primary caregiving responsibilities for both Samantha and my brother, juggling these duties alongside his fleeting work commitments.

As a consequence of this familial turmoil, I found myself neglected and adrift in a sea of emotional turmoil. In a harrowing episode, I attempted to drown my brother at the tender age of three, a manifestation of the profound distress and confusion that permeated our household. My struggles persisted into my early years of schooling, marked by clinginess and emotional outbursts that underscored the depths of my psychological distress.

I vividly recall the poignant scene of my first day of primary school, clinging desperately to Samantha as tears streamed down my face. Her helplessness was palpable as she watched me being led away from the classroom, seeking solace in the confines of a toy kitchen. It was a poignant moment emblematic of the perfect storm brewing within our family, encapsulating the profound sense of isolation and vulnerability that pervaded our lives. Yes, they weren’t perfect, but they were trying in ‘trying’ circumstances.

The trauma story

Our family's trauma story is marked by a tumultuous journey through domestic and family violence, leaving lasting wounds that deeply affected us.

After my sister’s birth, five years after mine, we were subjected to domestic and family violence. My parents argued about my mother's strained relationship with her own parents, financial troubles, and the isolating environment we found ourselves in.

My father had moved us from the inner suburbs, to the outer suburbs away from high rise buildings after my mother attempted to take her life. As a result, she was in and out of psychiatric hospitals, with her parents gradually withdrawing their support.

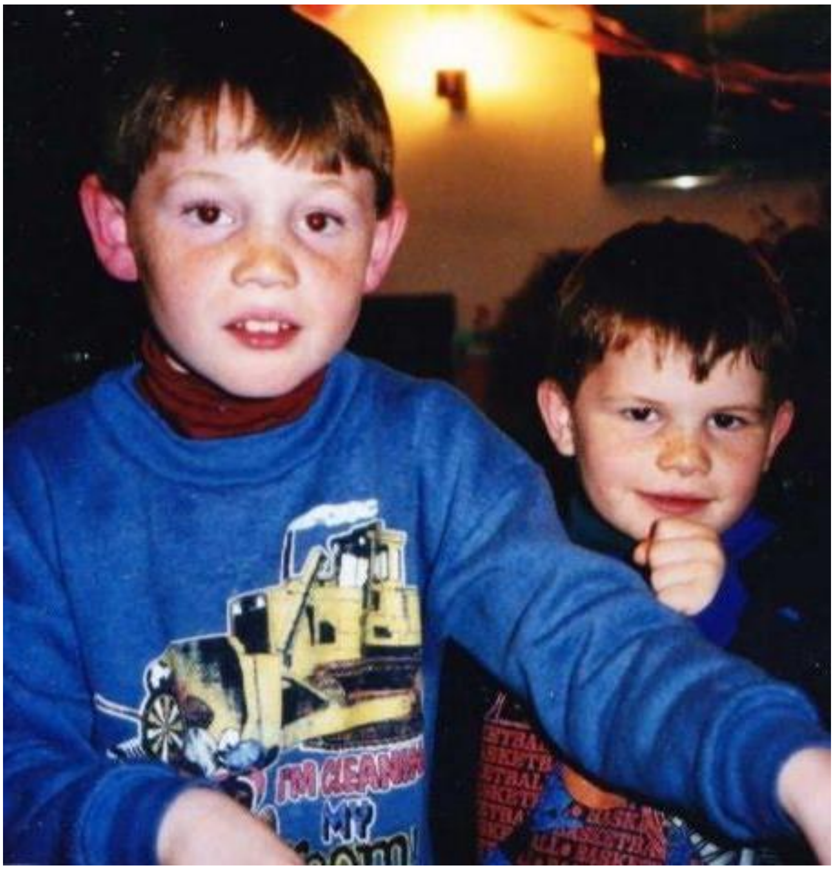


Image description: Two young boys looking into the camera. The boy on the left, the author aged 7, is wearing a blue sweater with a yellow bulldozer across the chest. The boy on the right, his younger brother aged 4, is wearing a black sweater with red lettering across the chest.

After their divorce, and their negligence, and impacts of violence, my siblings and I were placed into foster care as we had no one to care for us. It truly broke our mother's heart, but at just twenty-five years old, my mother faced an overwhelming burden, trying to raise three young children without support and while dealing with her own emotional struggles. The lack of support from both her partner and her own parents left her feeling hopeless and alone in her journey.

Image description: A portrait of a white woman sitting with her three children. The woman is wearing a pink and purple printed floral shirt with green leaves. The youngest child, sitting on the leftmost side, is wearing a white sweater with a blue, pink, and yellow vertical stripe pattern. The child sitting in the middle is wearing a red sweater with a graphic on the chest and a large white stripe down the sleeve. The oldest child, the author, is sitting on the right side, wearing a dark blue sweater with an image across the front. Everyone is facing forward and smiling into the camera.

Foster care: my first placement alone-isolated-disconnected. Othering, bullying and unwanted.

My isolated journey began with my first placement. We moved through four foster homes over five years, and initially, I was separated from my siblings. The sense of isolation, confusion, and profound grief has stayed with me ever since. I remember gazing out at the transformer power lines from my foster placement, yearning for home, only to realize it was just a few suburbs away. At school, I'd stare at the Dandenong Ranges radio towers, where my half-siblings lived, wondering if I could find my way there. Despite the challenges at home, being away from my siblings and parents felt even more daunting.

Feeling like an outsider was a constant struggle. Our mother battled suicidal thoughts every day for years. She had felt like such a failure as a person, a parent, and a mother, particularly at her choice in having children with our father. The shame, grief, loss and isolation from her own family had led her down a tunnel-visioned path of suicide.

In another foster home, a residential unit, we lived with two female carers, possibly a queer couple. While they were friendly, their own children always took precedence, leaving us feeling like second best. Whether it was the choice of food, toys, or Christmas presents, we always felt like the poor cousins. I remember their children getting a Furby, and wondering why we didn't. This feeling of being different, othered, and disadvantaged persisted.

That day: aged 9, I was told my mother suicided whilst I was in foster care.

Madness as survival

We went to forensic counselling, which always had an agenda.

In my mind, and the minds of many others, our grandparents had informed child welfare that our father abused my sister in an attempt for him to not regain custody. This was a tragic, resentful, and last-minute bid for power, and it kept us in foster care for one and a half years longer than we needed to be.

Eventually, it was un-substantiated and I fought tooth and nail as an eleven-year-old. Our father wasn't perfect, but he had never had any history of sexually abusing any of his eight children. Our counsellor at Windermere had a celebratory cake when we concluded our sessions after a year. We were literally laughing at her, and celebrating never having to be interrogated again – it was not therapeutic for me.

I didn't return to counselling until a decade later, thanks to poverty, engagement issues around anxiety and depression, and a lack of wrap-around support once in our father's care. I knew exactly what to say, how to say, and when to say it. I did all I could to protect my father and did what I had to do to get back in his care. He was all we had.

High school: different, 'anxious' and feeling unsafe space

I recall making a concerted effort to make friends with boys as I felt psychosocially deemed Madly-different by my peers. Feelings of comfort around girls and discomfort around boys began to grow.

I withdrew significantly from society aged fourteen and hid under my bed when it came time to attend school. Out of guilt, my father would often take me on his delivery runs; I felt liberated on the road, away from people and my inner demons. Listening to the radio was a way to keep me intellectually stimulated, avoid people, and provide me with a sense of hope about becoming a sports radio commentator. I still felt weird, othered and different, and realised much of this was due to my sexual attraction towards boys at the time, and the confusion of being in a hyper religious and homophobic environment.

Masking became a significant way to cope with Madness, and a transferable skill whether Mad, Queer and/or Neurodiverse.

My father had told me ‘homosexuals’ were diseased at aged fifteen, and I experienced the one ‘out’ kid at school being beaten by his bisexual boyfriend at the time at the back of the oval. My family and school continued to be unsafe spaces leading to Mad adaptations and a desperate need to ‘fit in’.

University: My struggling Mad ways of coping

I continued to struggle with my sexuality well into university to the point where I once again withdrew to avoid depth with fellow classmates.

My siblings had both experienced what Psychiatry defines as drug-induced psychosis at this time and I began to dip in and out of a caregiving/advocacy role in supporting my father to support them.

I tried to take my life, having moved out to a regional area, away from school friends, not having made any deep university connections, and desperately struggling with my sexuality and feeling ‘different’. It was the shame, loneliness and othering that led me to this pit of despair.

The disconnect with life, the othering and the anger at injustice was overwhelming.

Work: Retriggering complex trauma

I graduated into forensic mental health from my social work degree and found myself more comfortable in a predominantly gendered environment with women. For the first time I was celebrated, and in a political and social sciences context, I thrived. I thrived using my lived and living experience to make sense of the theory and research in advocacy/ social studies.

I learnt about the consumer movement and worked with a nationally awarded advocacy organisation and revered consumer advocate.

The experience of lateral violence in the family/carer space brought back those feelings of othering, disconnection, inadequacy which led to another suicide attempt and my first hospital admission. However, I was bullied in my second role, where I had worked in consumer and family/carer advocacy roles that were lived experience driven. I think it triggered a complex trauma response from all the violence I experienced or witnessed growing up. I learnt to withdraw.

This was the first of seven admissions, and consequently I have spent approximately a year of my life in hospital.

Hospitalisation: the ‘psych’ ward

In hospital, I learnt compassion and ways of surviving through peer support. I engaged with the spiritual/pastoral care worker and saw a psychotherapist/psychodrama practitioner who was quite dramatic herself. She helped me diffuse my experience of going home to be with my mother – it was destiny, it was fate, I told myself. “I am not dying, I am going home,” I told the emergency room nurse who stood by me and cried as I was oxygenated and sent to the Psy ward.

I learnt the importance of shared understanding, empathy, connection, pride, creative expression, groups… but this rarely translated into a sense of community beyond the hospital walls as we were directed to stay away from one another. I fought for our rights due to poor nutrition on the ward, only to be told this is no place for collective advocacy.

Phenomenal madness: ‘Euphoria’ Mania

Through my first hospitalisation I was placed on psychiatric drugs at the highest therapeutic dose for many months as I went to rehabilitation.

This led to what I think may have been my first long period of ‘euphoria’ – aka mania. It was an overcoming and overwhelming energy. I would continue to have these experiences in weekly/monthly phases, often stress induced. I loved feeling ‘euphoric’. I would see the world clearly; I could think systemically.

Ideas would come gushing out that I would have to record my notes in the early hours of the morning as I would go for runs, only to get home, and run again – I needed to burn this energy for sleep.

Euphoria was very spiritual at times, as I was transformed into an energy force with my mother, the lights would flicker as I spoke to her during a period of coming out as non-binary. I was very hurt by some of the negativity and backlash from a very public *LinkedIn* coming out.

I recall another time where I went to pray for my mother in the catholic church she had her funeral in. When I sat down on the front pew, the light shone on me, and I knew she was there in spirit, deeply connecting. No amount of medicine, science, psychiatry and ‘evidence-based practice’ could explain this phenomena.

I would go on to run a half marathon with no training after a period of hospitalisation and then euphoria and would channel my intense energy, ideas and motivation into listening to the *Bladerunner* soundtrack where synth sounds and symphony music would harness my energy and idea dumping onto paper, emails, social media posts etc….

I think much of my Mad coping was seeking answers, seeking truth, seeking connection and spiritual enlightenment. I was so lost for so many years. That euphoria had awakened a broken spirit and made me someone worthy of being heard.

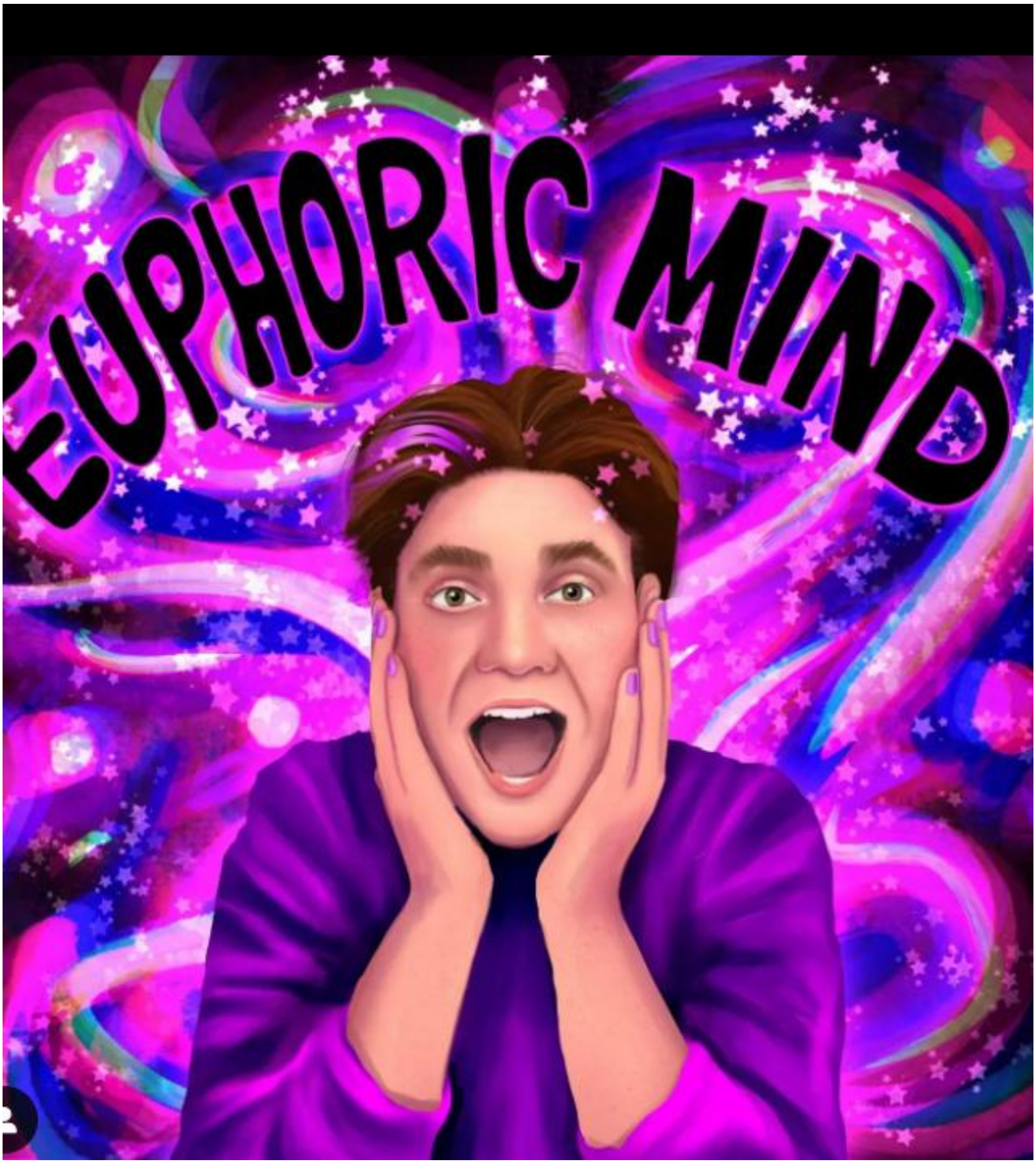


Image description: An illustrated image of the author named ‘euphoric mind’. The author is depicted with a beaming smile and hands placed on his cheeks in a state of euphoria. The author has short, auburn hair, and he is wearing a purple sweater and purple nail polish. The background shows a series of purple and pink swirls and swoops with blue, red and yellow accents. Large black block text reading EUPHORIC MIND is positioned in an arch above the author’s head.

Phenomenal madness: Suicidal

For a significant period, I found myself tracing a path eerily reminiscent of my mother's struggles with mental health. This journey was not just about grappling with personal challenges but also about confronting existential questions, wrestling with spiritual dilemmas, and navigating through a labyrinth of complex emotions. The weight of grief, trauma, guilt, and loss bore down heavily on my shoulders, and the relentless onslaught of neurodiversity, particularly ADHD, only compounded the struggle. In the depths of despair, the idea of suicide began to take root, fueled by the oppressive darkness of depression. It felt like being trapped in a suffocating abyss, where the world seemed to shrink, compressing inward, and offering little solace.

Despite the profound isolation and disconnection that accompanied these moments, there was a poignant sense of humanity in the depths of despair. It was a time of profound self-reflection, where I grappled with the depths of my own compassion, or lack thereof, and came face to face with the raw essence of empathy.

Rage as madness: Emotional overwhelm, injustice, and loss of hope

The seeds of rage took root in the fertile soil of injustice, nurtured by the bitter fruits of discrimination and despair. I harbored a deep-seated resentment towards the circumstances of my upbringing, directing my anger towards my parents, my grandparents, and the society that seemed intent on casting me aside. The weight of poverty, coupled with a profound lack of support and community, served as fuel for the fires of indignation that raged within me.

As I bore witness to repeated cycles of abuse and neglect, the flames of rage burned ever brighter, consuming everything in their path. In moments of despair, disassociation became a lifeline—a way to numb the overwhelming pain and disconnect from the harsh realities of the world. Yet, amidst the turmoil, there was a glimmer of understanding, a recognition of the circumstances that shaped people's behaviors, and a willingness to forgive, to extend grace, and to find solace in the face of adversity.

Psychosocial madness: Queer, gender-diverse, and non-binary

Another layer of complexity emerged from society's perception of queerness and gender diversity—a lens through which my experiences of otherness were refracted. My flamboyant personality, coupled with an unapologetic defiance of gender norms, marked me as different, setting me apart from the crowd. These experiences shaped my coping mechanisms, transforming the strategies I employed to navigate the tumultuous waters of mental health into tools for surviving the othering that accompanied being queer.

Madness to International Mad activism

I found myself through a period of euphoria travelling the world and presenting at the World Health Organisation (WHO) Mental Health Gap forum in 2018. I went onto the inaugural Global Ministerial Summit for Mental Health in the UK, and the Inaugural Western Pacific Lead for the Global Mental Health Peer Network. I have also been fortunate enough to contribute to peer work/ support as a discipline with CBM International and Harvard Global Mental Health.

I have trained in International Human Rights, Mental Health, and Law at the Indian Law Society. I am now a Lived Experience Consultant for WHO after involvement with various reports on alternatives and the framework for engaging meaningfully with people with lived experience.

The Mad Movement found me, and has given me a sense of connection, identity, belonging and community. I felt empowered to channel my rage against the system into positive action, and in doing so, gave voice to my mother and my own experiences. Advocacy became my greatest coping mechanism for Madness – it transformed the Madness from illness to gift!

Image description: A professional photograph of the author as an adult, depicting his role as a Lived Experience Consultant at the World Health Organisation. The author has short auburn hair, and he is wearing light brown glasses, and a light green and white gingham-patterned dress shirt. A World Health Organisation insignia is visible in the top right corner, and a light blue banner across the bottom of the image has white text that reads, 'Matthew Jackman: Lived Experience Consultant'.

4. The Mad Movement

The Mad Movement has been a transformative force in my life, providing a sense of belonging and empowerment that I hadn't found elsewhere. As I immersed myself in this movement, I began to realize the profound impact that collective advocacy and peer support can have on individual well-being and social change.

Attending conferences and events organized by the Mad Movement became more than just professional development opportunities; they were spaces of solidarity and validation. Sharing experiences and insights with fellow peers helped me feel seen and understood in a way that traditional mental health settings often couldn't provide.

Engaging with Alternatives to Suicide groups and other peer support initiatives allowed me to connect with others who shared similar struggles and experiences. These interactions were not only validating but also served as a reminder that I was not alone in my journey.

Becoming trained in Peer 'Specialist' work and interning with the Chief of Peer Services in California opened doors for me to contribute to the mental health field in meaningful ways. It allowed me to leverage my lived experience to support others on their recovery journeys and advocate for systemic changes within the mental health system.

Online platforms became essential avenues for connection and advocacy, offering spaces for critical dialogue and community building. Engaging in Mad Studies, Consumer, and Survivor groups provided me with opportunities to learn from diverse perspectives and contribute to important conversations about mental health reform.

Exploring artistic expression as a means of reclaiming agency and challenging societal norms has been particularly empowering. Through comedy, performance art, poetry, and visual art, I've found ways to articulate my experiences and challenge stigma surrounding madness. These creative outlets not only provide personal catharsis but also serve as powerful tools for advocacy and social change.

World Health Organisation Activism

In my work for the WHO, I’ve ensured that Mad perspectives and knowledge are incorporated into international mental health guidance documents such as the World Health Organisations ‘Framework for Engagement with People with Non Communicable Diseases, Mental health and Neurological Conditions’ and the Intention to Action series: People power.

What we really need is natural healers in our communities, we need peer support, we need strong families, strong communities. We need social justice, allied health, non-diagnostic ways and methods to support us Mad folk in distress.

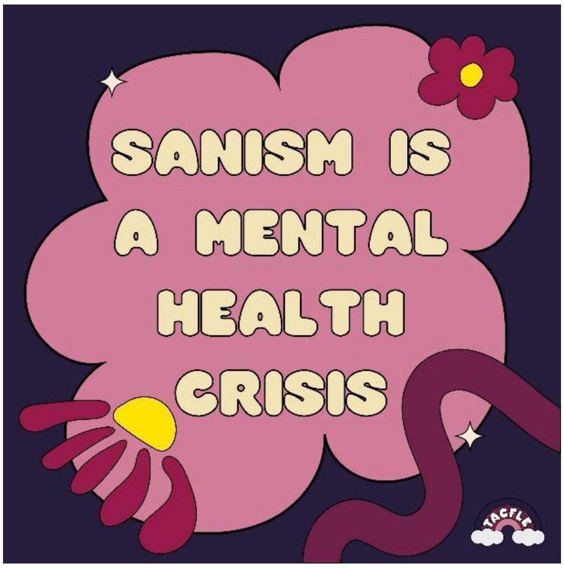


Image description: A digitally illustrated image on a black background. A mauve-y pink cloud silhouette is overlaid across the image, with light yellow block text that reads, ‘sanism is a mental health crisis’. Dark red and burgundy flowers and lines are placed in the top right, bottom left, and bottom right corners of the image. In the bottom right corner there is a rainbow icon with white text that reads, ‘TACFLE’.

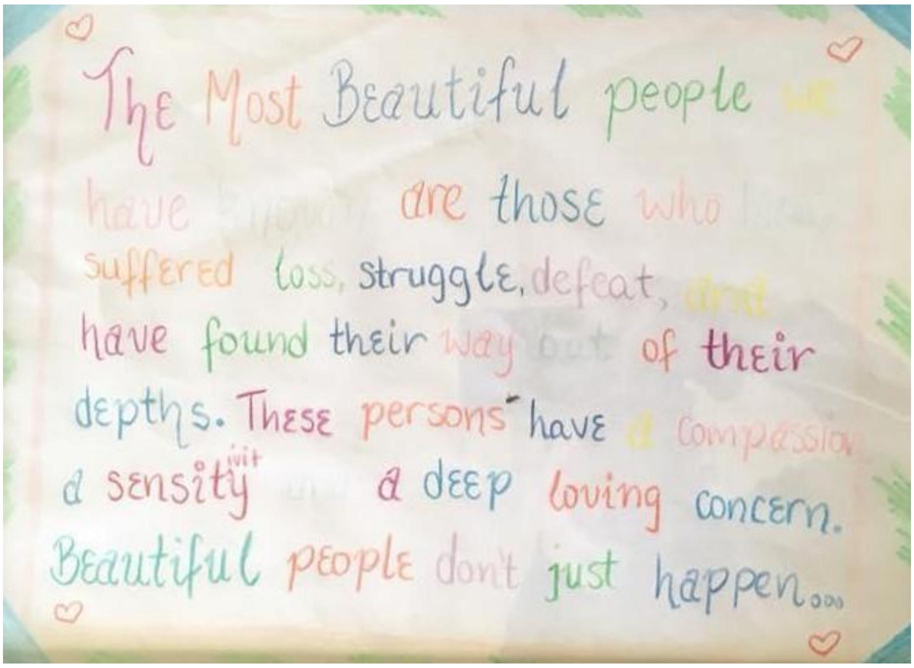
We are the data, we are the science, people with lived experience … I can’t stand it when people say ‘there’s data and there’s lived experience’ … There’s no binary.

The reality of the mental health system is that it’s colonized and patriarchal and it’s designed to entrench those that are oppressed, in oppressive conditions. Everything is blamed easily on the individual: ‘they’re depressed, they’re suicidal, they’ve got bipolar, they’re schizophrenic’, when the reality is that for many it’s actually the unjust conditions we live in that result in a lot of the distress and expression of distress that we experience.

We need a whole government, whole society response, including sustainable economic models and systems that move away from hierarchy to inclusivity and partnership. We need empathy, love, compassion, culturally-led, community driven, social justice-based communities that talk about power and how to share power.

Final words

It’s vital we get a shift in discourse – from medical to socio-cultural, spiritual, structural and Mad. My bipolar is part of who I am. It is a spiritual gift that has been brought about through interpersonal, family, community and societal trauma. It is a special gift in the face of consistent adversity and constant hypervigilance. A gift that requires harnessing, but a gift nonetheless.



The Most Beautiful people we
have known are those who have
suffered loss, struggle, defeat, and
have found their way out of their
depths. These persons have a compassion
a sensitivity and a deep loving concern.
Beautiful people don't just happen...

Image description: A picture of a quote written on a piece of paper with different coloured pencils used for each word. The author received this picture from a peer that he met during his first psychiatric hospital admission. The quote reads, "The most beautiful people we have known are those who has suffered loss, struggle, defeat, and have found their way out of their depths. These persons have a compassion, a sensitivity, and a deep loving concern. Beautiful people don't just happen."

Integrity statement: I declare that this manuscript is my original work, has not been published before and is not currently being considered for publication elsewhere. The work was based upon my own personal experiences from a first person perspective. I declare that the research was conducted ethically. I also declare that I own the copyright for all the images in this manuscript or have received the permissions required for their publication. I declare that I have no known competing financial or personal relationships that could be viewed as influencing the work reported in this paper.'

References

Bruce, L. M. J. (2021). *How to Go Mad without Losing Your Mind*. Duke University Press.